Print

State of Illinois
Department of Employment Security
www.ides.illinois.gov

Authorization (Appeals)

Dated: _____

Claimant ID/SSN.: _____

Docket No.: _____

I, _____ (Check One) (☐ Claimant ☐ Employer), in the above
(Print or Type Name)

reference Docket number hereby authorize:

Name: _____

Address: _____ Address 2: (Apt. / Suite / Floor / Etc.) _____

City: _____ State: _____ Zip Code: _____ _____

Telephone: _____ Ext: _____

to review my Appeal File. I understand that my Appeal File may be inspected at the Illinois Department of Employment Security's local office where the claim was filed or at the Illinois Department of Employment Security's main office at 33 South State Street, Chicago, Illinois, if such request is made at least two (2) working days prior to the hearing; where the request is timely made, the Illinois Department of Employment Security shall provide my authorized attorney or representative with an opportunity to inspect the file at least 24 hours prior to the hearing.

(Claimant / Employer)

Signature: _____

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